MONTANA MEDICAID CLAIM JUMPER

Volume X **The Montana Medicaid Newsletter** **AUGUST 2000**

Montana Medicaid Co-Payment Information

Individuals eligible for Montana Medicaid are responsible to pay co-payment amounts to providers of services. These amounts are particular to the service being provided and are detailed in Section V, Recipient Requirements, of the Montana Medicaid Provider Handbook.

CHILDREN (UNDER AGE 21), PREGNANT WOMEN, AND NURSING HOME RESIDENTS ARE EXEMPT FROM MAKING CO-PAYMENTS. Also, co-payment may not be charged for services provided for emergencies or family planning.

When you bill Montana Medicaid, do not show co-payment amounts as a credit, or other payment, on the claim form. The co-payment amount will be automatically deducted on your Remittance Advice.

Providers may choose to collect the co-payment at the time of service or bill the individual later. According to federal regulation, a provider cannot deny service to a Medicaid recipient due to the recipient's inability to pay the co-payment at the time the services are rendered.

The maximum co-payment per State Fiscal Year (July through June) is $200 per individual. The claims processing system tracks all co-payments applied for each Medicaid recipient. At the time the maximum cap of $200 is reached, no further co-payment is applied to paid claims. The recipient's co-payment cap information will appear on the Medicaid card as an asterisk in the "Co-Pay" column when the cap is reached.

PROVIDER SEMINAR LOCATIONS AND DATES ENCLOSED

HIPAA – A New Language in the New Millennium

This summer will begin the roll out of the final rules for the Administrative Simplification of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Over the next few years, these rules will guide providers and payers into a new world of electronic health care documentation. While the transition period may seem anything but simplified, the end result should prove beneficial for both providers and payers.

- All electronic billing will be in the same language and format. This will enable providers to bill Medicare, Medicaid, and private insurance using the same billing format. Those payers will be able to forward claims to the next payer without requiring the provider to submit another bill. By speaking the same electronic language, all payers will know exactly what the previous payer allowed and therefore what remains to be paid. Ultimately, payment should return to the provider much quicker.

- In addition to the standard language and format, coding will also become standardized. There will be a process to move Level III local codes into Level II HCPCS to maintain Medicaid specific programs, but HIPAA will eliminate all other local codes to improve standardization of electronic processing. These changes will take place over a two-year period of time, to make the transition easier.

- Security guidelines that are part of the HIPAA legislation will provide strict controls over the security of patient's medical records. Transmitting electronically will not jeopardize the confidentiality of patient records. In fact, audit controls over the handling of secure medical records will be available to assure patients and providers that records have only been accessed by those persons who have authority to do so.

- Providers of healthcare services will be issued a national provider identifier that will be used to bill all types of payers. Currently, providers have one number for Medicare, one or more for Medicaid, one for CHIP, and perhaps numerous others for other types of insurance. As soon as provider identifiers are assigned, there will no longer be confusion with conversion from one payer source to another.

- The transaction sets defined by the HIPAA standards will enable new types of electronic "conversations." Eligibility can be determined, benefits defined, prior authorization obtained, and benefits coordinated between payers - all done electronically. There will even be a transaction that allows providers to inquire about the status of a claim and payers to request additional information from the provider in an effort to generate a "clean claim" before adjudicating.

Stay tuned, the twenty first century will revolutionize medical records. We will use this forum to keep you posted regarding the rules as they are finalized. If you have any questions, please feel free to contact Consultec or Sally Klein, HIPAA Coordinator, at (406) 444-1460.

Recently Released Publications

The following is a list of publications released within the last quarter. If you would like extra copies of these publications, please contact Provider Relations.

Date	Sent to	Topic
4/3/2000	HCFA-1500 & UB-92 Billers	Prior Authorization Denials
4/10/2000	Ambulance Providers	Non-Emergency Ambulance Services
4/11/2000	School-Based Providers	Changes effective July 1, 2000
4/14/2000	Pharmacy Providers	H-2 Antagonists, Smoking Cessation Products, & Billing Decimals
4/26/2000	HCFA-1500 Billers	CPT-4 Coding Changes
5/15/2000	CHIP Dental Providers	CHIP Dental Changes
6/1/2000	All Providers	HMO Program Ending
6/7/2000	Dental Providers	Dental Implants Not Covered
6/13/2000	Pharmacy Providers	AWP Wholesale Pricing
6/15/2000	Dental Providers	Orthodontia Changes
6/22/2000	Hospital Providers	New DRG Grouper

Provider Relations Staff Available to Assist You

Consultec Provider Relations staff are available to assist providers from 8 a.m. to 5 p.m. Monday through Friday, except for major holidays. All provider relations phone representatives can answer questions relating to eligibility and claim status. If you submit claims electronically either through ACE$ or other means, technical support is available. However, any phone representative can help you if you submit electronically and have routine claim questions.

Third Party Liability's Ninety Day Rule

Montana Medicaid is considered the payer of last resort. This means that providers must bill any other potential payer and receive a response from that payer prior to billing Medicaid. However, if you have submitted your claim to another insurance company other than Medicare and have not received a response with in 90 days, you should send your claim along with a note stating when you billed the insurance company, to Consultec's Third Party Liability Unit, P.O. Box 5838, Helena, MT 59604.

Your claims will then be put through for processing and the Third Party Liability Unit will bill the insurance company.

INFORMATION TELEPHONE NUMBERS

Provider Relations	1-800-624-3958 (Montana Providers) 1-406-442-1837 (Helena and Out-of-State Providers) 1-406-442-4402 (FAX)		
FAXBACK	1-800-714-0075	AUTOMATED VOICE RESPONSE	1-800-714-0060
Point-of-Sale Help Desk	1-800-365-4944	PASSPORT	1-800-480-6823
Direct Deposit	1-406-444-5283		

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MONTANA MEDICAID

CONSULTEC

P.O. BOX 8000
HELENA, MT 59604

Timely Claims Follow-up

Timely follow-up of claim denials is the provider's responsibility. Regardless of the cause of the problem, it is the provider's responsibility to initiate appropriate action and follow-up to get claims issues resolved and to do so within the 365 day timely filing limit.

It is important for providers to review all claims on each Remittance Advice and take corrective action to resolve denied claims. If you experience claim problems, efforts should be made to resolve them through:

a. correction of all denial reasons and resubmission;
b. working with the county Office of Public Assistance if the denial was due to eligibility problems; or
c. contacting Provider Relations at Consultec.

ACE$ HELPFUL HINTS

Providers cannot use ACE$ to transmit their Medicare/Medicaid cross-over claims. However, if another payer, such as an insurance company, paid you can indicate the other payment as a TPL payment when you submit electronically with ACE$.

If you have a denial from an insurance company, or if the insurance allowed amount went towards the patients deductible, you will have to submit the applicable claim on paper with a copy of the insurance EOB attached.